Appendix F: Analysis of Grievance Procedures - Corporations Other Than HMOs

Methodology

In order to make comparisons about the grievance procedures in HMOs and other corporations, a sample of corporations with indemnity plans was generated by the Bureau of Insurance, State Corporation Commission. A total of twenty-one (21) companies, representing the highest volume of premiums, were chosen. Each company CEO was faxed a letter from Randolph Gordon, Commissioner of Health, asking for their participation in this study and requesting contact information. This information was compiled by the Virginia Department of Health and forwarded to the Department of Health Evaluation Sciences at the University of Virginia. Contact information was received for fifteen (15) companies.

As was done with the HMOs, a research assistant initiated contact with the people deemed most responsible for grievance procedures plans at each plan. In some cases, the research assistant was referred to other employees of the plan. Once the correct person was reached, the research assistant explained the purpose of the study and outlined the requirements of participation. When consent was obtained, the research assistant faxed the lists of questions relating to the grievance procedures. Each plan was instructed to complete the questions with relevant citations noted and to send current grievance procedures to DHES. They were requested to complete these tasks within 5 working days, and report back if they could not meet this deadline. Follow-up phone calls were utilized as reminders to those plans that did not respond within this time frame.

Questions for the study were provided by the Virginia Department of Health in consultation with the HB 2785 Study Group. All questions were sent to all potential participants in the study. Specific references to HMOs were stricken from the sets of questions sent to non-HMO companies.

The following companies were contacted regarding their grievance policies and procedures: Prudential, Mutual of Omaha, Employees Health Insurance, Trigon Blue Cross Blue Shield, AFLAC, The Guardian, Mass Mutual, UNUM, Principal Mutual Life, Portis, New York Life, State Farm Mutual Auto, Continental Assurance Company, Aetna, and Combined Insurance Company. Full responses were received from Mutual of Omaha, Employees Health Insurance, Prudential-MidAtlantic, New York Life, and Trigon. State Farm Mutual Auto, AFLAC, UNUM, and Combined Insurance Company reported that they do not have any managed care products and therefore did not have grievance procedures as defined in this study. Mass Mutual was dropped from the study because it had been sold twice and no appropriate person could be contacted during the study period. A tracking chart listing the plans and the status of their submissions follows the analysis of the grievance plans in this Appendix.

Once the documentation and completed questionnaires were received at DHES, the

researchers examined the answers and citations for completeness, accuracy, and clarity. Any questions were referred back to the individual plans. In addition, DHES interviewed appropriate personnel in order to supplement the information provided by the answers to the questions.

Analysis

Five non-HMO companies responded to our questions. Each question in the analytical framework has been answered using responses from all four companies, followed by comments from the researchers. In some cases, the answers to the questions were not explicitly stated in the grievance procedures for each plan. This has been noted where appropriate. It should be noted that "grievance procedures" was not terminology used by any of these companies; procedures appeared in many forms, including member handbooks, appeals documents, and complaint tracking plans. These documents were compared with the answers given to the study questions.

ANALYTICAL FRAMEWORK FOR EXAMINATION OF INDEMNITY (non-HMO) GRIEVANCE PROCEDURES

1. How does the plan member know about the grievance procedures?

Two plans stated that this information was in the member handbook and the member contract. The other three plans reported that letters are sent to the patient (and in two cases to the provider and the hospital) when services are denied; these letters outline the procedures. One plan mentioned that the appeals process is also communicated verbally when a client calls.

2. How many days does the plan member have after denial to ask for reconsideration?

Four plans allow 60 days; one plan stated that reconsideration could be requested at any time. This information was not explicitly stated in the grievance procedures for four plans, but it did appear in one.

3. Who makes the first attempt to resolve the complaint?

One plan stated that any person who receives a complaint attempts to resolve it. Two plans reported that the first person involved depends upon the type of complaint, but typically a nurse reviews the case initially. One plan utilizes an appeal team, and one company has a claims office that handles all complaints. This information was outlined in all grievance procedures.

4. How many days does the plan have to respond with a decision?

One plan reported 30 days. Two plans responded that expedited complaints are resolved within one business day, and all other complaints are resolved within 10 days after receipt of all

needed information. One plan noted that standard appeals are responded to within 10 days, prospective or current appeals within 1 or 2 days, and claims payment appeals within 7 days. One plan reported 60 days, but their grievance procedures stated that decisions should be made within 30 days. This information was in the grievance procedures for four plans (although one answer differed from what was in the procedures) and absent in one.

5. Do plan members have access to the names of members of the review panel?

Two plans said this information would be released upon request, one plan stated yes, and one plan noted that review panels are not used but the name of the reviewing physician is available. One plan noted that individuals are used for initial reviews, and they correspond directly with the member. If outside reviewers are needed, their names are not routinely provided. This was in the grievance procedures of only one plan.

6. Describe the first level of a formal appeal.

For all plans, senior staff are involved in the appeals process at this stage. The process included identification of the problem, referral to the appropriate decision-makers, case review, and member notification of the decision. The decision may be made by an individual, such as the Medical Director (two plans), Claims Specialist (one plan), other physician reviewers (two plans), or a combination of the above (one plan). All five plans described a first level appeal in their grievance procedures.

7. How many days does the plan have to respond?

One plan stated 10 days, one plan stated 10 days unless the appeal is expedited, one plan stated within 1 day for expedited appeals and within 2 days for standard appeals. One plan repeated their answers from Question 5. One plan reported that their review procedures are based on ERISA guidelines, which allow 60 days; however, their grievance procedures state that they must respond within 30 days.

8. Is there a second level appeal?

All plans report that second level appeals are available.

9. Does the plan member have a right to appear before the panel?

Three plans reported that plan members can appear before panels; this information was documented in one set of grievance procedures. Two plans do not use panels.

10. Is there a third level appeal?

Three plans stated that there is no third level appeal, but one of these plans mentioned that a decision may be reconsidered if new or additional information is received. One plan allows their enrollees a third level appeal to their Appeals Committee. This was documented in their grievance procedures. One plan replied that a third level appeal was available, but they did not describe the process.

11. Does the plan have expedited appeal?

All plans have expedited appeals, but one plan did not describe the process.

12. Can the plan member complain orally?

All plans allow enrollees to complain orally. One plan requires all retrospective appeals to be made in writing, and one plan noted that oral complaints are not tracked as part of the formal appeals process.

13. Are there accommodations for non-English speakers and the handicapped?

One plan simply stated yes, while the four other plans explained they had access to interpreters for non-English speaking enrollees and TTD devices for the hearing impaired. This information did not appear in any of the grievance procedures.

14. What happens when a member calls with a complaint or concern?

Three plans reported that all calls are documented and tracked in an electronic documentation system. The complaints are addressed, investigated, and resolved. One plan stated that whomever answers the call will attempt to resolve it or refer it on to their immediate supervisor. Another plan also has the receiver of the call try to resolve the issue, and allows for the caller to submit a formal appeal if they are not satisfied. This information is outlined in the grievance procedures of all plans.

15. Is there a tracking system?

All five plans have some form of tracking system. One plan tracks complaints relative to service and is currently developing a system relative to UR. Another plan tracks UR appeals and records (but does not aggregate) claims appeals. One plan uses both an electronic and written system. Tracking systems were described in four grievance procedures.

16. Are complaints made through the Bureau of Insurance tracked separately?

Four plans track these complaints separately. One plan includes them in their regular complaint tracking.

17. Is there anything unusual about the definition of a complaint?

One plan defined a complaint as "an expression of dissatisfaction regarding an administrative issue;" any other type of problem is defined as something else, such as a grievance. One plan defined this term as "an oral and written expression of dissatisfaction or a written request for an appeal. Grievances are not considered complaints." One plan defined a complaint as "any correspondence questioning the handling of a claim or the benefits paid." In addition, this plan separates and clearly defines complaints and grievances. Two plans stated that there was nothing unusual about the definition of a complaint. Three plans have a definition of complaint in their grievance procedures.

18. If the plan subcontracts with a mental health company, who handles complaints?

One plan reported that this depends on the nature of the complaint (administrative versus medical) and the contract with the specific provider. One plan stated that it depends upon the level of appeal. One plan stated that their outside vendors handle first and second level appeals and report results to the company; they do track and handle appeals that are made to them directly. Two plans do not subcontract with any mental health company or providers.

19. What is the basis for deciding medical necessity?

One plan uses established inpatient or outpatient criteria based on national guidelines that were included with their grievance procedures. Another plan uses written medical criteria and has a formal process for deciding medical necessity, which was attached to their grievance procedures. Another plan uses Milliman and Robertson and Medical Procedure Review criteria in conjunction with internally developed criteria, but this was not documented in the grievance procedures; these criteria are subject to annual review by the medical director and a committee of physicians. Two plans replied that they use peer developed, nationally accepted clinical criteria, but did not specify what the criteria were.

20. How are Medicaid grievances handled? Medicare? Federal Employees Health Benefit Plan (FEHBP)? Are grievance procedures different for these groups?

This question was not applicable to three plans. One plan does not enroll Medicaid beneficiaries, there is no difference for Medicare enrollees in terms of grievance procedures, and second appeals for FEHBP members are handled through OPM. This information was not in their grievance procedures. The plan that did not submit grievance procedures replied that they only handle Medicaid enrollees in Maryland, they use HCFA regulations for Medicare enrollees, and use OPM rules for FEHBP members.

21. Does the grievance procedure reference Chapter 54 of Title 38.2 of the Code of Virginia? Are the procedures commensurate with Chapter 54?

One plan does not specifically reference Chapter 54, but their grievance procedures include a chart outlining the appeals process that is commensurate with Chapter 54. Another plan reported that they are commensurate with Chapter 54, but it is not referenced in their grievance procedures. Three plans reference Chapter 54 in their grievance procedures.

22. May a provider acting on behalf of an enrollee initiate a grievance?

All five plans allow this practice. This was documented in two grievance procedures.

23. What are the positions and titles of the plan review committee that decides grievances?

One plan does not use a review committee; physicians decide all grievances. One plan has the Medical Director decide first appeals and uses a regional appeals committee (including an MD) for second appeals. One plan has at least five members, including the medical director, and another plan has a committee of six, including the claims specialist and the medical director. One plan stated that the committee members vary based on the type of appeal or review.

Comments: It is not clear if members are excused from the committee if they have been involved in prior decisions relating to the case.

Conclusions: Grievance procedures from the non-HMO companies were on the whole, more straightforward than those from HMO companies. Different definitions were given for complaints and grievances, and many of the details for grievances were outlined in the actual procedures. These companies did not use the term “grievance procedures”, so we analyzed the information they sent to us, which often included member handbooks.

NAME OF INDEMNITY GROUP	*QA PLAN*	*GP PLAN*
PRUDENTIAL MID-ATLANTIC	Not related	Responded to Questions but did not provide the Plan
MUTUAL OF OMAHA	1997	1991
EMPLOYERS HEALTH INSURANCE	1997	1997
TRIGON BLUE CROSS BLUE SHIELD	1997	1997
AFLAC	Responded - No related plans	Responded - No related plans
THE GUARDIAN	Did not respond	Did not respond
MASS MUTUAL	Did not respond	Did not respond
UNUM	Responded - No related plans	Responded - No related plans
TRAVERLERS	Did not respond	Did not respond
PRINCIPAL MUTUAL LIFE	Did not respond	Did not respond
COMBINED INS. CO.	Responded - No related plans	Responded - No related plans
PORTIS BENEFITS INS. CO.	Did not respond	Did not respond
NEW YORK LIFE	in the process of responding	in the process of responding
STATE FARM MUTUAL AUTO	Responded - No related plans	Responded - No related plans